Complete Summary

GUIDELINE TITLE

Substance use treatment modalities for HIV-infected persons.

BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Substance use treatment modalities for HIV-infected patients. New York (NY): New York State Department of Health; 2008 Jan. 13 p. [29 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: New York State Department of Health. Substance use treatment modalities for HIV-infected persons. New York (NY): New York State Department of Health; 2005 Jul. 11 p.

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SCOPE

DISEASE/CONDITION(S)

- Human immunodeficiency virus (HIV) infection
- Substance use, including use of heroin, cocaine, amphetamines, and benzodiazepines

GUIDELINE CATEGORY

Counseling
Management
Treatment

CLINICAL SPECIALTY

Allergy and Immunology
Family Practice
Infectious Diseases
Internal Medicine

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Nurses
Physician Assistants
Physicians
Public Health Departments
Substance Use Disorders Treatment Providers

GUIDELINE OBJECTIVE(S)

To provide guidelines for the treatment of substance use in human immunodeficiency virus (HIV)-infected patients

TARGET POPULATION

Human immunodeficiency virus (HIV)-infected patients who use heroin, cocaine, amphetamines, or benzodiazepines

INTERVENTIONS AND PRACTICES CONSIDERED

1. Discussing treatment options with substance using patients
2. Treatment for heroin addiction
    - Methadone or buprenorphine
    - Naltrexone as a second choice only
    - Patient counseling and other support resources
3. Treatment for stimulant and sedative dependence
4. Ensuring patients of confidentiality and obtaining written consent

MAJOR OUTCOMES CONSIDERED

Efficacy and safety of substance use treatment

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

AIDS Institute clinical guidelines are developed by distinguished committees of clinicians and others with extensive experience providing care to people with HIV infection. Committees* meet regularly to assess current recommendations and to write and update guidelines in accordance with newly emerging clinical and research developments.

The Committees* rely on evidence to the extent possible in formulating recommendations. When data from randomized clinical trials are not available, Committees rely on developing guidelines based on consensus, balancing the use of new information with sound clinical judgment that results in recommendations that are in the best interest of patients.

* Current committees include:

- Medical Care Criteria Committee
- Committee for the Care of Children and Adolescents with HIV Infection
- Dental Standards of Care Committee
- Mental Health Committee
- Women's Health Committee
- Substance Use Committee

- Physician's Prevention Advisory Committee
- Pharmacy Committee

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

Guideline developers reviewed a published cost analysis.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

All guidelines developed by the Committee are externally peer reviewed by at least two experts in that particular area of patient care, which ensures depth and quality of the guidelines.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Clinicians should be familiar with the substance use treatment programs and services available in their communities.

Selecting the Initial Substance Use Treatment Modality

Clinicians should discuss treatment options with substance-using patients and should ask which treatment options they prefer.

Clinicians should inquire about use of multiple substances and should consider the full spectrum of the patient's drug use when discussing treatment options with the patient.

Treatment for Heroin Addiction

Clinicians should offer agonist treatment to patients who are opioid-dependent and unable to discontinue use.

Clinicians should only use naltrexone as a second choice to agonist (methadone or buprenorphine) treatment to treat opioid dependence in human immunodeficiency virus (HIV)-infected patients.

Methadone Maintenance

Role of Counseling during Methadone Maintenance

Patients must receive counseling in order to receive medication in methadone maintenance programs.

Buprenorphine Treatment

Role of Counseling during Buprenorphine Maintenance

Counseling and other support resources should be made available to all patients treated with buprenorphine.

Patients who decline counseling services should be maintained on buprenorphine if otherwise medically appropriate.

Naltrexone Treatment

Clinicians should only use naltrexone as a second choice to agonist (methadone or buprenorphine) treatment to treat opioid dependence in HIV-infected patients. Strong supports should be in place to maximize adherence and treatment retention.

Clinicians should not use oral naltrexone until patients are opioid-free for 3 to 4 days.

Clinicians should not use oral naltrexone in patients with acute hepatitis or liver failure.

Key Point:

Oral naltrexone is not a highly recommended therapy for the following reasons:

- It has a very low retention rate.
- Concern about its safety in the setting of liver disease
- It blocks the analgesic effects of opioid agonists and should be discontinued 72 hours prior to elective surgery.
- There is an elevated risk of fatal overdose upon discontinuation of oral naltrexone therapy.

Medication-Assisted Opioid Withdrawal

Clinicians should not initiate medication-assisted opioid withdrawal in opioid-dependent pregnant women. Rather, opioid-dependent pregnant women should be referred for treatment in a methadone maintenance treatment program.

See the original guideline document for information about treatment for stimulant and sedative dependence; non-pharmacologic treatment modalities, including twelve-step programs and acupuncture; and substance-use treatment settings.

Communication and Confidentiality

Clinicians should inform substance-using HIV-infected patients of the laws governing confidentiality of both HIV status and substance use treatment.

Clinicians should obtain written consent from the patient before communicating with substance use treatment programs.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate substance use treatment in human immunodeficiency virus (HIV)-infected patients

POTENTIAL HARMS

Adverse Effects of Medications

- The most common adverse effects of *methadone* maintenance are constipation and increased sweating. Because of its relatively long half-life, excessively rapid dose escalation at the beginning of methadone treatment can put patients at risk for overdose. High doses of methadone have been associated with uncommon instances of torsade de pointes. When stopped abruptly, methadone causes longer, but milder, withdrawal than the brief, but more intense, withdrawal from heroin.
- If *buprenorphine* is withdrawn abruptly, the withdrawal symptoms are thought to be less severe than those experienced with methadone or heroin. Because of its high affinity for the opioid receptor and its partial agonist characteristics, buprenorphine will precipitate symptomatic withdrawal when taken by an opioid-dependent person who is not already in withdrawal. For this reason, patients need to be in moderate withdrawal before initiating buprenorphine treatment; patients in moderate withdrawal will experience relief of withdrawal symptoms upon initiation of buprenorphine treatment. The most widely used formulation (Suboxone) is mixed with naloxone, which has no significant activity when taken sublingually but is active when injected. Thus, if the medication is injected, the user will either experience withdrawal if dependent or experience an attenuated effect if not dependent. A number of buprenorphine-related deaths from overdose have been reported in France; all were among patients who were misusing benzodiazepines or benzodiazepines plus alcohol. Reports have also indicated elevated serum liver enzyme levels and subclinical hyperlactatemia, but the clinical relevance

of these findings is unclear. Buprenorphine is metabolized by the hepatic enzyme system P450 3A4; therefore, clinicians should be alert to the possibility of interactions with inhibitors, such as non-nucleoside reverse transcriptase inhibitor (NNRTIs), protease inhibitors (PIs), azoles, and macrolides, and inducers, such as phenobarbital, carbamazepine, phenytoin, and rifampicin.
- High doses of *naltrexone* can cause hepatocellular injury. There is an elevated risk of fatal overdose upon discontinuation of oral naltrexone therapy.

CONTRAINDICATIONS

CONTRAINDICATIONS

- Contraindications to *buprenorphine* include:
    - Patients who need ongoing opioid-based pain management or who heavily misuse benzodiazepines should not be considered for buprenorphine treatment.
    - The US Food and Drug Administration (FDA) considers pregnancy to be a contraindication; however, many clinicians feel that buprenorphine is a safer alternative to methadone or heroin use. If buprenorphine is prescribed during pregnancy, the buprenorphine monopreparation (Subutex) should be used.
- *Oral naltrexone* should not be used until patients are opioid-free for 3 to 4 days. Oral naltrexone should not be used in patients with acute hepatitis or liver failure.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The AIDS Institute's Office of the Medical Director directly oversees the development, publication, dissemination and implementation of clinical practice guidelines, in collaboration with The Johns Hopkins University, Division of Infectious Diseases. These guidelines address the medical management of adults, adolescents and children with HIV infection; primary and secondary prevention in medical settings; and include informational brochures for care providers and the public.

Guidelines Dissemination

Guidelines are disseminated to clinicians, support service providers and consumers through mass mailings and numerous AIDS Institute-sponsored educational programs. Distribution methods include the HIV Clinical Resource website, the Clinical Education Initiative, the AIDS Educational Training Centers (AETC) and the HIV/AIDS Materials Initiative. Printed copies of clinical guidelines are available for order from the NYSDOH Distribution Center for providers who lack internet access.

Guidelines Implementation

The HIV Clinical Guidelines Program works with other programs in the AIDS Institute to promote adoption of guidelines. Clinicians, for example, are targeted through the Clinical Education Initiative (CEI) and the AIDS Education and Training Centers (AETC). The CEI provides tailored educational programming on site for health care providers on important topics in HIV care, including those addressed by the HIV Clinical Guidelines Program. The AETC provides conferences, grand rounds and other programs that cover topics contained in AIDS Institute guidelines.

Support service providers are targeted through the HIV Education and Training initiative which provides training on important HIV topics to non-physician health and human services providers. Education is carried out across the State as well as through video conferencing and audio conferencing.

The HIV Clinical Guidelines Program also works in a coordinated manner with the HIV Quality of Care Program to promote implementation of HIV guidelines in New York State. By developing quality indicators based on the guidelines, the AIDS Institute has created a mechanism for measurement of performance that allows providers and consumers to know to what extent specific guidelines have been implemented.

Finally, best practices booklets are developed through the HIV Clinical Guidelines Program. These contain practical solutions to common problems related to access, delivery or coordination of care, in an effort to ensure that HIV guidelines are implemented and that patients receive the highest level of HIV care possible.

IMPLEMENTATION TOOLS

Personal Digital Assistant (PDA) Downloads

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness
Safety

IDENTIFYING INFORMATION AND AVAILABILITY

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2005 Jul (revised 2008 Jan)

GUIDELINE DEVELOPER(S)

New York State Department of Health - State/Local Government Agency [U.S.]

SOURCE(S) OF FUNDING

New York State Department of Health

GUIDELINE COMMITTEE

Substance Use Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Chair: Marc N Gourevitch, MD, MPH, New York University School of Medicine , New York, New York

Members: Bruce D Agins, MD, MPH, New York State Department of Health AIDS Institute, New York, New York; Julia H Arnsten, MD, MPH, Montefiore Medical Center, Bronx, New York; Lawrence S Brown, Jr, MD, MPH, FASAM, Addiction Research and Treatment Corporation, Brooklyn, New York; Brenda Chabon, PhD, Montefiore Medical Center, Bronx, New York; Barbara H Chaffee, MD, MPH, Binghamton Family Care Center, Binghamton, New York; Michael L Christie, MD, AIDS Community Health Center, Rochester, New York; Chinazo O Cunningham, MD; Montefiore Medical Center, Bronx, New York; Nereida L Ferran-Hansard, MD, Jacobi Medical Center, Bronx, New York; Steven S Kipnis, MD, FACP, FASAM, New York State Office of Alcoholism and Substance Abuse Services, Orangeburg, New York; Joseph P Merlino, MD, MPA, Mount Sinai School of Medicine, New York, New York; Nancy Murphy, NP, St. Luke's Roosevelt Hospital Center, New York, New York; Edward Nunes, MD, New York State Psychiatric Institute, New York, New York; David C Perlman, MD, Beth Israel Medical Center, New York, New York; Sharon L Stancliff, MD, Harm Reduction Coalition, New York, New York; Robert Whitney, MD, Erie County Medical Center, Buffalo, New York

Liaisons: Daliah I Heller, MPH, Liaison to the New York City Department of Health and Mental Hygiene, New York, New York

AIDS Institute Staff Liaisons: Diane M Rudnick, MEd, Liaison to the New York State Department of Health AIDS Institute, New York, New York

AIDS Institute Staff Physician: Eunmee H Chun, MD, New York State Department of Health AIDS Institute, New York, New York

Principal Contributors: Steven L Batki, MD, SUNY Upstate Medical University, Syracuse; John AR Grimaldi, Jr, MD, New York-Presbyterian Hospital/Weill Cornell Medical Center, New York

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

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GUIDELINE AVAILABILITY

Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.

AVAILABILITY OF COMPANION DOCUMENTS

This guideline is available as a Personal Digital Assistant (PDA) download from the New York State Department of Health AIDS Institute Web site.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on September 19, 2007. This NGC summary was updated by ECRI Institute on June 12, 2008.

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